Report of Accident (Workplace Injury, Accident or Occupational Disease)

Language preference (check one) ☒ English ☐ Español/Spanish ☐ русский/Russian ☐ Tiếng Việt/Vietnamese ☐ 繁體中文/Chinese Traditional ☐ 简体中文/Chinese Simplified ☐ 한국어/Korean ☐ ខ្មែរ/Cambodian ☐ Soomaali/Somali ☐ Other: Admit

Claim No. B [redacted]

Worker Information

1. Name (First-Middle-Last): Warren John Peterson
2. ☐ Male ☐ Female
3. Social Security Number: [redacted]
4. Home phone: [redacted]
5. Birth date: month / day / year
6. Home address: [redacted]
7. Height (Ft-In.)
8. Weight
City: East Olympia State: WA ZIP Code: 98540
9. Mailing address (if different from home address)
City State ZIP Code
10. Family status: ☑ Married ☐ Widowed ☐ Separated ☐ Single ☐ Divorced ☐ Registered Domestic Partner

Family and dependent eligibility: *You may be required to show proof of marriage, domestic partnership registration, or dependent eligibility.*

Dependent Information

11. Dependent children Include unborn/ estimate birth date. Benefits will be based in part on number of legally dependent children. If you don't have legal custody, complete Box 13.

Name	Relationship	Legal Custody	Birth date
		☐ YES ☐ NO	/ /
		☐ YES ☐ NO	/ /
		☐ YES ☐ NO	/ /
		☐ YES ☐ NO	/ /
		☐ YES ☐ NO	/ /

12. Name of Spouse or Registered Domestic Partner: Launi Peterson
13. Name & address of children's legal guardian
Name Address
City State ZIP Code

Injury Information

14. Date of injury or last occupational exposure: 5/26/19
15. Time of injury: : ☐ AM ☐ PM
16. Shift (check one) ☐ Day ☐ Swing ☐ Night
17. Have you ever been treated for the same or similar condition? ☐ YES ☒ NO
18. Is this condition due to a specific incident? ☑ YES ☐ NO
19a. Body parts injured or exposed:
19b. Describe in detail how your injury or exposure occurred. (Include tools, machinery, chemicals or fumes that may have been involved)
20. Were you doing your regular job? ☑ YES ☐ NO
21. Where did the injury or exposure occur? ☐ Employer Premises ☐ Jobsite ☐ Other:
22. Where did the injury/exposure occur? Name of business:
Address City County State ZIP
23. Injury caused by a faulty machine, product or person other than my employer or co-worker? ☐ YES ☐ NO ☐ POSSIBLY
24. List any witnesses:
25. When will you return to work? / /
26. When did you last work? 5/26/19
27. Did you report the incident to your employer? ☐ YES ☐ NO If "yes" write name and title:
28. Date you reported it: / /
29. Did you have employer-paid health care benefits on the day injured? ☐ YES ☐ NO

Employment Information

30. Business name of your employer: Thurston County Fire Dist. 6
31. Type of business
32. How long have you worked there? ____ Years ____ Months ____ Weeks ____ Days
33. Employer's phone: 360 491 5533
34. Your employer's address: P.O. Box 578
City: East Olympia State: WA ZIP Code: 98540
35. List your job title and describe your job duties
36. Rate of pay at this job (check one) ☐ Hour ☐ Week ☐ Day ☐ Month ☐ More than 1 rate of pay $
37. Hours per day
38. Days per week
39. Additional earnings (daily average) $ (check all that apply) ☐ Piecework ☐ Regular overtime ☐ Commission ☐ Tips ☐ Shift diff. ☐ Bonuses in the last 12 months
40. How many paying jobs do you have?
41. I am a: ☐ Owner ☐ Partner ☐ Corp. Officer ☐ Corp. Shareholder ☐ Corp. Director ☐ Optional Coverage ☐ Does not apply to me

42. Signature **Note: READ LEGAL NOTICES ON THE WORKER'S COPY OF THIS FORM**
I declare these statements are true to the best of my knowledge and belief. In signing this form, I permit health care providers, hospitals, or clinics to release relevant medical reports, which they or others produce, to the Dept. of Labor & Industries.
X Today's date / /

43. Signature
I authorize the Department of Labor & Industries, or others acting on their behalf, to obtain confidential employment records from the Employment Security Department (ESD) to help determine workers' compensation benefits.
X Today's date / /

Health Care Provider Information

1. Diagnosis	2. ICD Codes	1. Diagnosis	2. ICD Codes

3. Date you first saw patient for this condition. / /
Claim No. [redacted]
4. Is the condition due to a specific incident? ☐ YES ☐ NO
5. Objective findings supporting your diagnosis (Include physical, lab and X-ray findings)
6a. Is more treatment needed? ☐ YES ☐ NO ☐ POSSIBLY
6b. Treatment and diagnostic testing recommendations:
7. Was the diagnosed condition caused by this injury or exposure? **Check one.** ☐ YES ☐ PROBABLY (51% or more) ☐ NO ☐ POSSIBLY (Less than 50%)
8. Will the condition cause the patient to miss work? ☐ YES ☐ NO
If yes, estimate the number of days:
9. Is there any pre-existing impairment of the injured area? ☐ YES ☐ NO
If YES, describe briefly or attach report.
10. Has patient ever been treated for the same or similar condition? ☐ YES ☐ NO
If YES, provider name, city & year: Name City Year
11. Are there any conditions that will prevent or slow recovery? ☐ YES ☐ NO
If YES, describe briefly or attach report.
12. Did you refer the patient to an L&I medical network provider for follow-up? ☐ YES ☐ NO
Referred to:
13. Name of attending health care provider (Please print)
Patient's ID number, if available: [redacted]
14. **IMPORTANT: L&I Provider Number or NPI of provider listed in Box 13.**
15a. Name of hospital or clinic where patient was treated:
Name HMC 325 9th Ave
Address Seattle WA 98104
Phone 206 744-4074 State ZIP
15b. This exam date / /
16. Signature (NOTE: Licensed health care provider must sign report.)
X Today's date / /